STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

July 3, 2018

Marna P. Borgstrom, President /CEO
Yale New Haven Hospital
20 York Street
New Haven, CT

Dear Ms. Borgstrom:

Unannounced visits were made to Yale New Haven Hospital concluding on April 2, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through June 22, 2018.

Attached is a violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **July 17, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

An telephone conference has been scheduled for **July 18, 2018** at **2:00 PM** to discuss the violation with an asterisk (*). Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please call me directly to participate in this meeting (860) 509-7436.

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: March 6, 14 and April 2, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cheryl A. Davis, R.N., B.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CAD:jf

Complaint #22804

DATES OF VISIT: March 6, 14 and April 2, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

1. *Based on clinical record review, interview, and policy review, for one of three patients reviewed for restraints, (Patient #1) the facility failed to conduct a comprehensive patient assessment and/or document specific alternatives tried and/or the rationale why less restrictive interventions were ineffective, prior to the administration of an antipsychotropic medication. The finding include the following:
    a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of the physician H&P dated 10/30/17 noted that the patient was unable to move lower extremities due to paralysis and had upper extremity strength 5/5 (score of 5 indicated normal muscle strength). The patient was alert and following commands with a normal mood and affect with waxing and waning mentation.

    Review of RN #1's nursing note dated 11/1/17 at 5:04 AM indicated that at 8:00 PM (on 10/31/17) when the nurse entered the room to introduce herself, the patient smiled and responded "ok get out. I don't want you as my nurse". The patient requested to speak to the person in charge. At this time the patient began to refuse care including vital signs. The note identified that the charge nurse spoke to the patient then notified the off Shift Supervisor that there were concerns and questioned whether it was racially related given patient's comments and reaction to certain staff members. By 10:00 PM, RN #1 came back to check on the patient and allowed nurse to complete vital signs and a partial assessment. Medications were offered and the patient stated "ok put them down and get out" as the patient's behavior suddenly changed. The physician was made aware of the situation. By 2:00 AM, the nurse discovered that the patient's medications were noted to be scattered on the bed. Medications were removed from the bed and while walking around the bed to adjust the light, the patient hit the nurse's arm and made a derogatory comment. The patient began screaming "help me", and subsequently hit a second nurse in the arm with the call bell and continued to make derogatory comments. MD #1 was notified and a one-time order of Haldol 2 milligrams intramuscular (IM) was ordered. The note indicated that the patient required assistance of four staff members to administer the medication. At about 4:00 AM, the patient was asleep and resting well, will continue to monitor.

DATES OF VISIT: March 6, 14 and April 2, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of the 7PM-7AM, charge nurse's note dated 10/31-11/1/17 identified that the patient was yelling racial slurs and derogatory remarks toward staff, swinging his/her television remote at staff, mocking staff, and upsetting the patient's roommate. One dose of Haldol was ordered and administered. While giving the medication, held patient's arms down from swinging and attempting to bite staff. Patient eventually fell asleep and was monitored frequently by nurse for safety concerns.

Review of the physician's order dated 11/1/17 at 2:09 AM directed the administration of Haldol 2 milligrams, injection, once. The order failed to reflect the rationale for the medication and/or an order for a therapeutic hold (to hold or limit voluntary movement by using body contact as a method of physical restraint).

A nursing assessment dated 11/1/17 at 5:00 PM identified a maroon/purple bruise on the patient's left wrist measured 14 centimeters (cm) by 6 cm. Review of MD #2's addendum note dated 11/2/17 identified that a family meeting was held with the events of 11/1/17 evening reviewed. Patient with probable sun-downing and agitated delirium which escalated over the evening. The patient needed to be restrained while IM Haldol was administered which may have led to the left wrist injury.

Interview with the charge nurse on 3/18/18 at 8:00 AM stated the patient was agitated, throwing things and was screaming racial slurs. The physician was notified and gave a one-time order for Haldol. The patient was swinging so one staff member each held down an arm in order to administer the medication. The charge nurse was unable to recall which staff held the patient's arms during medication administration.

Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1, a travel nurse, was not available for interview.

Interview with MD #1 on 3/14/18 at 3:30 PM indicated he was called by the RN that the patient was physically abusive and aggressive and had to be held down for medication administration. MD #1 identified that rationale for the medication was for the patient to calm down.

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The facility administered a chemical restraint and a therapeutic hold in order to administer a psychotropic medication absent a comprehensive assessment of the patient including documentation of alternative measures tried and utilization of the least restrictive device possible.

Review of the Restraint & Seclusion policy defined a restraint as; any manual method, physical, or mechanical device that immobilizes or reduces the ability of the patient to move his/her arm, legs, body or head freely, including, but not limited to: the application of force to physically hold a patient in order to administer a medication against the patient's wishes and/or any medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not the standard treatment or dosage for the patient's condition.

The policy further identified that restraints may only be used when less restrictive interventions have been determined to be ineffective or inappropriate to protect the patient or others from harm. The type or technique of restraint must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others form harm.

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2. *Based on a review of clinical records, review of facility documentation, interviews, and policy review, for one of three patients' reviewed for abuse (Patient #1) the hospital failed to ensure that an allegation of abuse was thoroughly investigated. The finding include the following:
   a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of the physician H&P dated 10/30/17 noted that the patient was unable to move lower extremities due to paralysis, with flaccid extremities and 0/5 (score of 5 indicated normal muscle strength) strength in both lower extremities and has sensation to touch bilaterally. The patient's upper extremity strength is 5/5. The patient was alert and following commands with a normal mood and affect with waxing and waning mentation.

      Review of RN #1's nursing note dated 11/1/17 at 5:04 AM indicated that at 8:00 PM when the nurse entered the room to introduce herself the patient smiled and responded "ok get out. I don't want you as my nurse". The patient requested to speak to the person

in charge. At this time the patient began to refuse care including vital signs. The note identified that the charge nurse spoke to the patient then notified the off Shift Supervisor that there were concerns and questioned whether it was racially related given patient's comments and reaction to certain staff members. By 10:00 PM, RN #1 came back to check on the patient and allowed nurse to complete vital signs and a partial assessment. Medications were offered and the patient stated "ok put them down and get out" as the patient's behavior suddenly changed. The physician was made aware of the situation. By 2:00 AM, the nurse discovered that the patient's medications were noted to be scattered on the bed. Medications were removed from the bed and while walking around the bed to adjust the light, the patient hit the nurse's arm and made a derogatory comment. The patient began screaming "help me", and subsequently hit a second nurse in the arm with the call bell and continued to make derogatory comments. MD #1 was notified and a one-time order of Haldol 2 milligrams intramuscular (IM) was ordered. The note indicated that the patient required assistance of four staff members to administer the medication. At about 4:00 AM, the patient was asleep and resting well, will continue to monitor. Review of the 7PM-7AM, charge nurse's note dated 10/31-11/1/17 identified that the patient was yelling racial slurs and derogatory remarks toward staff, swinging his/her television remote at staff, mocking staff, and upsetting the patient's roommate. 1 dose of Haldol was ordered and administered. While giving the medication, held patient's arms down from swinging and attempting to bite staff. Patient eventually fell asleep and was monitored frequently by nurse for safety concerns.

The nurse's note dated 11/1/17 at 8:30 AM identified that the patient was noted with left wrist edema, propped up on pillows, and went off the unit for an ultrasound of the left ulna.

On 11/1/17 at 1:29 PM, a Physician's Assistant (PA) directed to obtain an x-ray of the patient's left radius/ulna. The clinical record failed to reflect that the patient was examined by the PA and/or a physician on 11/1/17 following notification of the left wrist swelling.

Review of the radiological results noted the wrist was difficult to evaluate for fractures secondary to positioning. The impression included, soft tissue swelling without evidence of fracture.

A nursing assessment dated 11/1/17 at 5:00 PM identified a maroon/purple bruise on the patient's left wrist measured 14 centimeters (cm) by 6 cm.

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Review of MD #2's addendum note dated 11/2/17 identified that a family meeting was held with the events of 11/1/17 evening reviewed. Patient with probable sundowning and agitated delirium which escalated over the evening. The patient needed to be restrained while IM Haldol was administered which may have led to the left wrist injury. Will have orthopedics evaluate. There is no evidence of this being a deliberate act by any of the staff.

The nurse's note dated 11/2/17 at 1:28 AM identified that the patient had a bruise with a swollen left wrist with ice applied.

Review of an orthopedic consultation for left wrist pain dated 11/3/17 at 12:38 PM identified that the patient reportedly became verbally abusive and had to be sedated with Haldol. It is unclear if s/he had to be physically restrained resulting in bruising to the left volar forearm region. Swelling and ecchymosis was noted over the volar aspect of the left forearm to which the patient reports pain and is tender to palpation. A recommendation was made to elevate to reduce swelling, no splinting necessary, alright to apply ice if tolerated.

Interview with the charge nurse on 3/18/18 at 8:00 AM stated that she was asked to speak with the patient as s/he was refusing care from RN #1. The charge nurse identified the patient did not want to speak with her and requested to speak to "someone above me", therefore the nurse executive was notified. The charge nurse stated later that evening, she heard yelling for help coming from the room and upon entering, the patient was agitated, throwing things and was screaming racial slurs. The physician was notified and gave a one-time order for Haldol. The patient was swinging so one staff member each held down an arm in order to administer the medication. The charge nurse was unable to recall which staff held the patient's arms during medication administration.

Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1 was not available for interview.

Review of facility documentation dated 11/1/17 indicated a Patient Relations representative met with Person #1 on 11/1/17, who wanted to file a complaint related to

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"elder abuse" secondary to an incident that resulted in swelling and bruising of Patient #1's left wrist. Interview with the Director of Patient Relations on 3/14/18 at 11:45 AM stated she was aware of the issue and the claim of elder abuse, however was unable to provide evidence that staff had been interviewed and/or how the decision was made that the claim was unsubstantiated. The Director indicated that family meetings were held and that the case could have been handled better. The Director was unable to provide evidence that a comprehensive investigation had been completed.

Review of the Roles and Responsibilities in reference to an Allegation of Abuse/Neglect of a Patient identified that the hospital staff treat patients with respect and dignity and will assist in all possible ways possible to provide the safety of the patient. The process in part, identified that Patient relations will receive notification of the incident and coordinates a huddle within 24 hours which includes but is not limited to; Manager, Employee Relations, OSE, and Protective Services. Protective services will meet with the Manager, OSE, and Patient Relations to conduct interviews, with both the patient and the accused, create an incident report, determine if a physical examination is needed, and if the patient would like to press charges. Employee Relations will be an active part of the investigation if the accused is an employee and will determine the outcome for the accused.

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3. *Based on a review of clinical records, facility documentation, interview and policy review, for one of three patients' reviewed for abuse (Patient #2), the hospital failed to ensure that an allegation of abuse was promptly reported. The finding includes the following:
   a. Patient #2 was admitted to the hospital on 10/22/16 with worsening confusion, poor appetite and reported fall. Review of the Physician Assistant's note dated 3/14/18 at 9:56 PM, indicated the PA was called to evaluate the patient at approximately 5:15 PM for a complaint of being hit in the stomach. The assessment was completed and no issues were identified.

   Review of the facility investigation (immediate response algorithm) dated 3/14/18 identified that a grievance was initiated when a Manager called to report that NA #1 told four (4) other staff members that she punched Patient #2 in the gut because s/he was becoming combative when trying to give a shower. Documentation identified that the Manager stated RN #2 reported that the conversation occurred around two weeks ago and she could not sleep struggling with the information told to her and co-workers. Written statements were obtained from staff including NA #1. Review of NA #1's statement dated 3/14/18 indicated that on 3/6/18 she was at the nursing station

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discussing a situation with co-workers that had occurred months previous. She indicated while helping a co-worker wash Patient #2, the patient became violent and physically punched staff in their bellies. NA #1 stated she pushed both of the patient's hands away, held them down, and told the patient to keep his/her hands to his/herself or else she would hit the patient back. NA #1 denied hitting the patient and denied telling co-workers that she hit the patient.

Interview with RN #2 on 4/2/18 at 12:40 PM stated she should have reported the incident earlier however was afraid of repercussions.

Interview with the Manager on 4/2/18 at 10:30 AM stated all staff receive annual abuse education and all staff should have reported the allegation immediately.

Review of the facility policy on abuse indicated that any employee who learns of abuse/neglect to a patient or experiences concern for patient safety should immediately report the concerns to the supervisor.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

4. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for medication administration (Patient #1), the facility failed to ensure that medications were not left at the bedside upon refusal resulting in the patient not receiving medications as ordered. The finding includes the following:
    a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of a nurse's note dated 11/1/17 at 5:04 AM indicated that at 10PM (on 10/31/17), the covering nurse went to check on the patient and at this time the patient allowed the nurse to check vital signs and do a partial assessment. Medications were offered and the patient stated "Ok, put them down and get out", as behavior suddenly changed. By 2:00 AM, nurse discovered patient medications were scattered on the bed, and the medications were removed from the bed. Review of the MAR on 3/6/18 at 1:00 PM with the covering Manager indicated that for the period of 10/31-11/1/17, nine (9) doses of medication were not administered. The MAR failed to identify a reason for not administering the medications for six (6) doses. The Manager further stated that a reason should be documented when a medication is not administered.

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The policy for Medication Administration indicated that the nurse ensures oral medications are taken by the patient as prescribed and documentation should reflect, in part, the rationale for not administering scheduled medications.

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5. Based on a review of clinical records, interview and policy review, for one patient who experienced a change of condition (Patient #1), the hospital failed to ensure the POA was notified in a timely manner. The finding includes the following:
   a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of the physician H&P dated 10/30/17 noted that the patient was unable to move lower extremities due to paralysis, with flaccid extremities and 0/5 (score of 5 indicated normal muscle strength) strength in both lower extremities and has sensation to touch bilaterally. The patient's upper extremity strength is 5/5. The patient was alert and following commands with a normal mood, and affect with waxing and waning mentation.

      Review of RN #1's nursing note dated 11/1/17 at 5:04 AM indicated that at 8:00 PM when the nurse entered the room to introduce herself the patient smiled and responded "ok get out. I don't want you as my nurse". The patient requested to speak to the person in charge. At this time the patient began to refuse care including vital signs. The note identified that the charge nurse spoke to the patient then notified the off Shift Supervisor that there were concerns and questioned whether it was racially related given patient's comments and reaction to certain staff members. By 10:00 PM, RN #1 came back to check on the patient and allowed nurse to complete vital signs and a partial assessment. Medications were offered and the patient stated "ok put them down and get out" as the patient's behavior suddenly changed. The physician was made aware of the situation. By 2:00 AM, the nurse discovered that the patient's medications were noted to be scattered on the bed. Medications were removed from the bed and while walking around the bed to adjust the light, the patient hit the nurse's arm and made a derogatory comment. The patient began screaming "help me", and subsequently hit a second nurse in the arm with the call bell and continued to make derogatory comments. MD #1 was notified and a one-time order of Haldol 2 milligrams intramuscular (IM) was ordered. The note indicated that the patient required assistance of four staff members to administer the medication. At about 4:00 AM, the patient was asleep and resting well, will continue to

monitor. Review of the 7PM-7AM, charge nurse's note dated 10/31-11/1/17 identified that the patient was yelling racial slurs and derogatory remarks toward staff, swinging his/her television remote at staff, mocking staff, and upsetting the patient's roommate. 1 dose of Haldol was ordered and administered. While giving the medication, held patient's arms down from swinging and attempting to bite staff. Patient eventually fell asleep and was monitored frequently by nurse for safety concerns.

Review of MD #2's addendum note dated 11/2/17 identified that a family meeting was held with the events of 11/1/17 evening reviewed. Patient with probable sundowning and agitated delirium which escalated over the evening. The patient needed to be restrained while IM Haldol was administered which may have led to the left wrist injury. Will have orthopedics evaluate. There is no evidence of this being a deliberate act by any of the staff.

Review of an orthopedic consultation for left wrist pain dated 11/3/17 at 12:38 PM identified that the patient reportedly became verbally abusive and had to be sedated with Haldol. It is unclear if s/he had to be physically restrained resulting in bruising to the left volar forearm region. Swelling and ecchymosis was noted over the volar aspect of the left forearm to which the patient reports pain and is tender to palpation.

Interview with the charge nurse on 3/18/18 at 8:00 AM stated that she was asked to speak with the patient as s/he was refusing care from RN #1. The charge nurse identified the patient did not want to speak with her and requested to speak to "someone above me", therefore the nurse executive was notified. The charge nurse stated later that evening, she heard yelling for help coming from the room and upon entering, the patient was agitated, throwing things and was screaming racial slurs. The physician was notified and gave a one-time order for Haldol. The patient was swinging so one staff member each held down an arm in order to administer the medication. The charge nurse was unable to recall which staff held the patient's arms during medication administration.

Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1 was not available for interview.

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Review of the grievance filed by the POA on 11/1/17 indicated that he/she was upset that s/he was not notified of the change and/or incident until 12:30 PM on 11/1/17.

Review of the clinical record with staff on 3/6/18 at 1PM stated there was a delay in the notification of the patient's responsible party when the patient experienced a change in behavior.

POC accepted SMD 7/31/18

Yale NewHaven Health
Yale New Haven Hospital

July 31, 2018

Cheryl A. Davis, RN, BSN
Supervising Nurse Consultant
Facility Licensing and Investigations Sections
410 Capital Avenue-MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

RE: Yale New Haven Hospital Letter of Violation, July 3, 2018
Response Amended July 31, 2018

Dear Ms. Davis,

Please find attached Yale New Haven Hospital's (YNHH) response to your letter of July 3, 2018 containing plans of correction and response for the violations set forth in the letter that was amended on July 31, 2018.

If you need additional information, please contact me via email at jean.zimkus@ynhh.org or by phone at (203) 688-6374.

Sincerely,

Jean Zimkus

Jean Zimkus, MSN, RN, HACP, CJCP
Accreditation and Regulatory Specialist
Clinic Building, 1st Floor, Room CB1049J
Yale New Haven Health
20 York Street
New Haven, CT 06510

JZ:jd:enclosure

CC: Thomas Balcezak
Marna Borgstrom
Richard D'Aquila

FACILITY: Yale New Haven Hospital

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FACILITY: Yale New Haven Hospital

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Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1, a travel nurse, was not available for interview.

Interview with MD #1 on 3/14/18 at 3:30 PM indicated he was called by the RN that the patient was physically abusive and aggressive and had to be held down for medication

administration. MD #1 identified that rationale for the medication was for the patient to calm down.

The facility administered a chemical restraint and a therapeutic hold in order to administer a psychotropic medication absent a comprehensive assessment of the patient including documentation of alternative measures tried and utilization of the least restrictive device possible.

Review of the Restraint & Seclusion policy defined a restraint as; any manual method, physical, or mechanical device that immobilizes or reduces the ability of the patient to move his/her arm, legs, body or head freely, including, but not limited to: the application of force to physically hold a patient in order to administer a medication against the patient's wishes and/or any medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not the standard treatment or dosage for the patient's condition.

The policy further identified that restraints may only be used when less restrictive interventions have been determined to be ineffective or inappropriate to protect the patient or others from harm. The type or technique of restraint must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others form harm.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1a. DPH Plan of Correction	Completion Date
• The Hospitalist Advance Practice Providers (APP) and Attending Providers will be re-educated on the Restraint and Seclusion Policy.	August 15, 2018
• The Hospitalist Advance Practice Providers (APP) and Attending Providers will be re-educated on the requirement to document a rationale when administering Haldol with a frequency of one time.	August 15, 2018
• This event will be shared at the Hospitalist Monthly Staff meetings emphasizing the use of a physical hold as a restraint, necessitating an order.	August 15, 2018
• Monitoring Plan: o Ten medical records per month or all if less will be audited on patients with a Haldol order with a frequency of one time for documentation of indication. o Beginning: September 5, 2018	October 26, 2018
• The Executive Director of the Hospitalist Service has been designated to oversee the monitoring of these corrective actions.	
• Saint Raphael's Campus clinical registered nurses on Celentano 4 and Medical/Surgical clinical registered nurses from the Nursing Resource Operations Center (NROC), will be re-educated on the Restraint and Seclusion Policy and documentation of a physical hold.	August 31, 2018
• Monitoring Plan: o Saint Raphael's Campus clinical registered nurses on Celentano 4 and Medical/Surgical clinical registered nurses from the NROC will complete a case study and post-test regarding a physical hold. o Beginning: July 19, 2018	August 31, 2018
• The Patient Service Manager of Celentano 4 and Interim Director of Nursing Resource Operations Center are designated to oversee the monitoring of these corrective actions.	

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6).

2. *Based on a review of clinical records, review of facility documentation, interviews, and policy review, for one of three patients' reviewed for abuse (Patient #1) the hospital failed to ensure that an allegation of abuse was thoroughly investigated. The finding include the following:

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a. Patient #1 was admitted to the hospital on 10/30/17 with metabolie encephalopathy seeondary to sepsis and a urinary tract infeetion (UTI). The patient's past medieal history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia seeondary to an inoperable spinal meningioma. Review of the physician H&P dated 10/30/17 noted that the patient was unable to move lower extremities due to paralysis, with flaecid extremities and 0/5 (score of 5 indieated normal muscle strength) strength in both lower extremities and has sensation to touch bilaterally. The patient's upper extremity strength is 5/5. The patient was alert and following eommands with a normal mood and affect with waxing and waning mentation.

Review of RN #1's nursing note dated 11/1/17 at 5:04 AM indicated that at 8:00 PM when the nurse entered the room to introduce herself the patient smiled and responded "ok get out. I don't want you as my nurse". The patient requested to speak to the person in eharge. At this time the patient began to refuse care including vital signs. The note identified that the charge nurse spoke to the patient then notified the off Shift Supervisor that there were concerns and questioned whether it was raeially related given patient's eomments and reaction to certain staff members. By 10:00 PM, RN #1 eame back to cheek on the patient and allowed nurse to complete vital signs and a partial assessment. Medications were offered and the patient stated "ok put them down and get out" as the patient's behavior suddenly changed. The physieian was made aware of the situation. By 2:00 AM, the nurse discovered that the patient's medications were noted to be seattered on the bed. Medications were removed from the bed and while walking around the bed to adjust the light, the patient hit the nurse's arm and made a derogatory comment. The patient began sereaming "help me", and subsequently hit a seeond nurse in the arm with the eall bell and eontinued to make derogatory comments. MD #1 was notified and a one-time order of Haldol 2 milligrams intramuseular (IM) was ordered. The note indicated that the patient required assistance of four staff members to administer the medication. At about 4:00 AM, the patient was asleep and resting well, will continue to monitor. Review of the 7PM-7AM, charge nurse's note dated 10/31-11/1/17 identified that the patient was yelling racial slurs and derogatory remarks toward staff, swinging his/her television remote at staff, mocking staff, and upsetting the patient's roommate. 1 dose of Haldol was ordered and administered. While giving the medieation, held patient's arms down from swinging and attempting to bite staff. Patient eventually fell asleep and was monitored frequently by nurse for safety eoneerns.

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The nurse's note dated 11/1/17 at 8:30 AM identified that the patient was noted with left wrist edema, propped up on pillows, and went off the unit for an ultrasound of the left ulna.

On 11/1/17 at 1:29 PM, a Physician's Assistant (PA) directed to obtain an x-ray of the patient's left radius/ulna. The clinical record failed to reflect that the patient was examined by the PA and/or a physician on 11/1/17 following notification of the left wrist swelling.

Review of the radiological results noted the wrist was difficult to evaluate for fractures secondary to positioning. The impression included, soft tissue swelling without evidence of fracture.

A nursing assessment dated 11/1/17 at 5:00 PM identified a maroon/purple bruise on the patient's left wrist measured 14 centimeters (cm) by 6 cm.

Review of MD #2's addendum note dated 11/2/17 identified that a family meeting was held with the events of 11/1/17 evening reviewed. Patient with probable sundowning and agitated delirium which escalated over the evening. The patient needed to be restrained while IM Haldol was administered which may have led to the left wrist injury. Will have orthopedics evaluate. There is no evidence of this being a deliberate act by any of the staff.

The nurse's note dated 11/2/17 at 1:28 AM identified that the patient had a bruise with a swollen left wrist with ice applied.

Review of an orthopedic consultation for left wrist pain dated 11/3/17 at 12:38 PM identified that the patient reportedly became verbally abusive and had to be sedated with Haldol. It is unclear if s/he had to be physically restrained resulting in bruising to the left volar forearm region. Swelling and ecchymosis was noted over the volar aspect of the left forearm to which the patient reports pain and is tender to palpation. A recommendation was made to elevate to reduce swelling, no splinting necessary, alright to apply ice if tolerated.

Interview with the charge nurse on 3/18/18 at 8:00 AM stated that she was asked to speak with the patient as s/he was refusing care from RN #1. The charge nurse identified the

patient did not want to speak with her and requested to speak to "someone above me", therefore the nurse executive was notified. The charge nurse stated later that evening, she heard yelling for help coming from the room and upon entering, the patient was agitated, throwing things and was screaming racial slurs. The physician was notified and gave a one-time order for Haldol. The patient was swinging so one staff member each held down an arm in order to administer the medication. The charge nurse was unable to recall which staff held the patient's arms during medication administration.

Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1 was not available for interview.

Review of facility documentation dated 11/1/17 indicated a Patient Relations representative met with Person #1 on 11/1/17, who wanted to file a complaint related to "elder abuse" secondary to an incident that resulted in swelling and bruising of Patient #1's left wrist. Interview with the Director of Patient Relations on 3/14/18 at 11:45 AM stated she was aware of the issue and the claim of elder abuse, however was unable to provide evidence that staff had been interviewed and/or how the decision was made that the claim was unsubstantiated. The Director indicated that family meetings were held and that the case could have been handled better. The Director was unable to provide evidence that a comprehensive investigation had been completed.

Review of the Roles and Responsibilities in reference to an Allegation of Abuse/Neglect of a Patient identified that the hospital staff treat patients with respect and dignity and will assist in all possible ways possible to provide the safety of the patient. The process in part, identified that Patient relations will receive notification of the incident and coordinates a huddle within 24 hours which includes but is not limited to; Manager, Employee Relations, OSE, and Protective Services. Protective services will meet with the Manager, OSE, and Patient Relations to conduct interviews, with both the patient and the accused, create an incident report, determine if a physical examination is needed, and if the patient would like to press charges. Employee Relations will be an

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active part of the investigation if the accused is an employee and will determine the outcome for the accused.

2a.	DPH Plan of Correction	Completion Date
	• The Hospitalist Advance Practice Providers (APP) and Attending Providers will be re-educated to document a comprehensive exam when evaluating a suspected patient injury. • The Executive Director of the Hospitalist Service has been designated to oversee the monitoring of these corrective actions.	August 15, 2018
	• Yale New Haven Hospital Patient Relations service enhanced the "Algorithm for Allegation of Sexual Abuse and/or Physical Assault of a Patient While in Our Care" to ensure a thorough investigation will occur following an allegation of abuse. Complaint and grievance data is reported annually at the Patient Safety and Clinical Quality Committee of the Board of Trustees.	July 13, 2018
	• The updated algorithm was presented at the Patient Service Manger (PSM) Council meeting. • Monitoring Plan: o All allegations of sexual abuse and/or physical assault investigations will be reviewed to ensure the "Algorithm for Allegation of Sexual Abuse and/or Physical Assault of a Patient While in Our Care" was followed, for 2 months. o Beginning: July 30, 2018 • The Manager of Patient Relations at Yale New Haven Hospital was designated to oversee the monitoring of these corrective actions.	July 26, 2018 September 28, 2018

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6).

3. *Based on a review of clinical records, facility documentation, interview and policy review, for one of three patients' reviewed for abuse (Patient #2), the hospital failed to ensure that an allegation of abuse was promptly reported. The finding includes the following: a. Patient #2 was admitted to the hospital on 10/22/16 with worsening confusion, poor appetite and reported fall. Review of the Physician Assistant's note dated 3/14/18 at 9:56 PM, indicated the PA was called to evaluate the patient at approximately 5:15 PM for a complaint of being hit in the stomach. The assessment was completed and no issues were identified.

   Review of the facility investigation (immediate response algorithm) dated 3/14/18 identified that a grievance was initiated when a Manager called to report that NA #1 told four (4) other staff members that she punched Patient #2 in the gut because s/he was becoming combative when trying to give a shower. Documentation identified that the Manager stated RN #2 reported that the conversation occurred around two weeks ago and she could not sleep struggling with the information told to her and co-workers. Written statements were obtained from staff including NA #1. Review of NA #1's statement dated 3/14/18 indicated that on 3/6/18 she was at the nursing station discussing a situation with co-workers that had occurred months previous. She indicated while helping a co-worker wash Patient #2, the patient became violent and physically punched staff in their bellies. NA #1 stated she pushed both of the patient's hands away, held them down, and told the patient to keep his/her hands to his/herself or else she would hit the patient back. NA #1 denied hitting the patient and denied telling co-workers that she hit the patient.

   Interview with RN #2 on 4/2/18 at 12:40 PM stated she should have reported the incident earlier however was afraid of repercussions.

   Interview with the Manager on 4/2/18 at 10:30 AM stated all staff receive annual abuse education and all staff should have reported the allegation immediately.

   Review of the facility policy on abuse indicated that any employee who learns of abuse/neglect to a patient or experiences concern for patient safety should immediately report the concerns to the supervisor.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

3a. DPH Plan of Correction	Completion Date
• Yale New Haven Hospital-York Street Campus East Pavilion (EP) 9-7 clinical nursing staff and patient care associates will be reeducated on the Abuse: Identification and Management of Patients Suspected to have Suffered Physical Abuse/Neglect, Emotional Abuse/Neglect, Domestic Violence Sexual Abuse Policy and Procedure.	July 31, 2018
• Human Resources and Corporate Compliance will provide education through staff safety huddles on EP 9-7 to include: o Statutory/Regulatory consequences of not reporting abuse on discovery o Employment consequences of not reporting abuse on discovery o The importance of immediately reporting abuse to a supervisor, using the chain of command and use of the Corporate Compliance hotline	August 31, 2018
• Yale New Haven Hospital Nursing Leadership will be informed regarding availability of above education and mechanism to schedule the educational program.	August 31, 2018
• EP 9-7 patient care associates will receive a geriatric dementia awareness training class which will include de-escalation training.	August 31, 2018
• Yale New Haven Hospital Nursing Leadership will be informed of the availability of the Geriatric dementia awareness training program.	August 31, 2018
• Monitoring Plan: o Two clinical EP 9-7 staff will be assessed for understanding when and how to report any suspected abuse per week for two months. o Beginning: August 1, 2018 o Audits will be conducted on EP 9-7 for timely reporting of any allegation of abuse for two months. o Beginning: August 1, 2018	September 28, 2018 September 28, 2108
• The Patient Service Manager of EP 9-7 has been designated to oversee the execution and monitoring of these corrective actions.	

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

4. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for medication administration (Patient #1), the facility failed to ensure that medications were not left at the bedside upon refusal resulting in the patient not receiving medications as ordered. The finding includes the following:

a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of a nurse's note dated 11/1/17 at 5:04 AM indicated that at 10PM (on 10/31/17), the covering nurse went to check on the patient and at this time the patient allowed the nurse to check vital signs and do a partial assessment. Medications were offered and the patient stated "Ok, put them down and get out", as behavior suddenly changed. By 2:00 AM, nurse discovered patient medications were scattered on the bed, and the medications were removed from the bed. Review of the MAR on 3/6/18 at 1:00 PM with the covering Manager indicated that for the period of 10/31-11/1/17, nine (9) doses of medication were not administered. The MAR failed to identify a reason for not administering the medications for six (6) doses. The Manager further stated that a reason should be documented when a medication is not administered.

The policy for Medication Administration indicated that the nurse ensures oral medications are taken by the patient as prescribed and documentation should reflect, in part, the rationale for not administering scheduled medications.

4a.	DPH Plan of Correction	Completion Date
	• Saint Raphael's Campus clinical registered nurses on Celentano 4 and Medical/Surgical clinical registered nurses from the Nursing Resource Operations Center (NROC) will be re-educated to ensure medications are not left at the bedside upon refusal and to document the reason for not administering a medication. • Monitoring Plan: o Five medical records per week for 4 weeks will be audited on Celentano 4, to ensure medication documented as 'not given' include the reason for not administering the medication. o Beginning: September 4, 2018 • The Patient Service Manager of Celentano 4 and Interim Director of Nursing Resource Operations Center are designated to oversee the monitoring of these corrective actions.	August 31, 2018 October 2, 2018

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1) and/or 6) General (6).

5. Based on a review of clinical records, interview and policy review, for one patient who experienced a change of condition (Patient #1), the hospital failed to ensure the POA was notified in a timely manner. The finding includes the following:
   a. Patient #1 was admitted to the hospital on 10/30/17 with metabolic encephalopathy secondary to sepsis and a urinary tract infection (UTI). The patient's past medical history included, in part, left eye blindness, kidney stones with ureteral stenting, neurogenic bladder, hypertension, diabetes, and paraplegia secondary to an inoperable spinal meningioma. Review of the physician H&P dated 10/30/17 noted that the patient was unable to move lower extremities due to paralysis, with flaccid extremities and 0/5 (score of 5 indicated normal muscle strength) strength in both lower extremities and has sensation to touch bilaterally. The patient's upper extremity strength is 5/5. The patient was alert and following commands with a normal mood and affect with waxing and waning mentation.

   Review of RN #1's nursing note dated 11/1/17 at 5:04 AM indicated that at 8:00 PM when the nurse entered the room to introduce herself the patient smiled and responded "ok get out. I don't want you as my nurse". The patient requested to speak to the person in charge. At this time the patient began to refuse care including vital signs. The note identified that the charge nurse spoke to the patient then notified the off Shift Supervisor that there were concerns and questioned whether it was racially related given patient's comments and reaction to certain staff members. By 10:00 PM, RN #1 came back to check on the patient and allowed nurse to complete vital signs and a partial assessment. Medications were offered and the patient stated "ok put them down and get out" as the patient's behavior suddenly changed. The physician was made aware of the situation. By 2:00 AM, the nurse discovered that the patient's medications were noted to be scattered on the bed. Medications were removed from the bed and while walking around the bed to adjust the light, the patient hit the nurse's arm and made a derogatory comment. The patient began screaming "help me", and subsequently hit a second nurse in the arm with the call bell and continued to make derogatory comments. MD #1 was notified and a one-time order of Haldol 2 milligrams intramuscular (IM) was ordered. The note indicated that the patient required assistance of four staff members to administer the medication. At about 4:00 AM, the patient was asleep and resting well, will continue to monitor. Review of the 7PM-7AM, charge nurse's note dated 10/31-11/1/17 identified that the patient was yelling racial slurs and derogatory remarks toward staff, swinging his/her television remote at staff,

mocking staff, and upsetting the patient's roommate. 1 dose of Haldol was ordered and administered. While giving the medication, held patient's arms down from swinging and attempting to bite staff. Patient eventually fell asleep and was monitored frequently by nurse for safety concerns.

Review of MD #2's addendum note dated 11/2/17 identified that a family meeting was held with the events of 11/1/17 evening reviewed. Patient with probable sundowning and agitated delirium which escalated over the evening. The patient needed to be restrained while IM Haldol was administered which may have led to the left wrist injury. Will have orthopedics evaluate. There is no evidence of this being a deliberate act by any of the staff.

Review of an orthopedic consultation for left wrist pain dated 11/3/17 at 12:38 PM identified that the patient reportedly became verbally abusive and had to be sedated with Haldol. It is unclear if s/he had to be physically restrained resulting in bruising to the left volar forearm region. Swelling and ecchymosis was noted over the volar aspect of the left forearm to which the patient reports pain and is tender to palpation.

Interview with the charge nurse on 3/18/18 at 8:00 AM stated that she was asked to speak with the patient as s/he was refusing care from RN #1. The charge nurse identified the patient did not want to speak with her and requested to speak to "someone above me", therefore the nurse executive was notified. The charge nurse stated later that evening, she heard yelling for help coming from the room and upon entering, the patient was agitated, throwing things and was screaming racial slurs. The physician was notified and gave a one-time order for Haldol. The patient was swinging so one staff member each held down an arm in order to administer the medication. The charge nurse was unable to recall which staff held the patient's arms during medication administration.

Interview with RN #3 on 3/8/18 at 8:15 AM identified that she recalled hearing the patient screaming from the nurse's station and upon entering the room, the patient threw an unopened can of soda across the room, was swinging the call light and yelling racial slurs. RN #3 stated she held the patient's right arm and RN #1 held her left arm while Haldol was administered in the patient's thigh.

RN #1 was not available for interview.

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Review of the grievance filed by the POA on 11/1/17 indicated that he/she was upset that s/he was not notified of the change and/or incident until 12:30 PM on 11/1/17.

Review of the clinical record with staff on 3/6/18 at 1PM stated there was a delay in the notification of the patient's responsible party when the patient experienced a change in behavior.

5a. DPH Plan of Correction	Completion Date
• The medical record will be reviewed with the provider caring for the patient during a change in condition reinforcing the need to notify the Power of Attorney (POA) in a timely fashion when a patient experiences a change in condition.	August 15, 2018
• This event will be shared at the Hospitalist Monthly Staff meetings emphasizing the need to notify the POA in a timely fashion when a patient experiences a change in condition.	August 15, 2018
• The Executive Director of the Hospitalist Service has been designated to oversee the monitoring of these corrective actions.	